MEDICATION PERMISSION AND INSTRUCTIONS FOR DAY CARE HOMES/CHILD CARE CENTERS STATE OF MICHIGAN

Family Independence Agency
Office of Children and Adult Licensing

If you are giving or applying any medication to a day care child, the following must be completed by the parent for **each** medication. An interruption in medication will require a new permission form.

(Provider, Facility) , to my child (Specify, prescribed medication/over the counter products) (Child's Name) DIRECTIONS: Date to Begin Giving Medication 2. Date to Stop Medication 3. Times Medication is to be Given 4. Amount (dosage) of Medication Each Time Given 5. Storage of Medication 6. Other Directions, if Any	I give my permission for			to give or apply	the medication
(Specify, prescribed medication/over the counter products) (Child's Name) DIRECTIONS: Date to Begin Giving Medication 2. Date to Stop Medication 3. Times Medication is to be Given 4. Amount (dosage) of Medication Each Time Given 5. Storage of Medication 6. Other Directions, if Any Date Date	T give my permission for	(Provide	r, Facility)	to give or apply	r the medication,
DIRECTIONS: Date to Begin Giving Medication 2. Date to Stop Medication 3. Times Medication is to be Given 4. Amount (dosage) of Medication Each Time Given 5. Storage of Medication 6. Other Directions, if Any Signature of Parent Date			, to my child	(0)	, as follows
Date to Begin Giving Medication 2. Date to Stop Medication 3. Times Medication is to be Given 4. Amount (dosage) of Medication Each Time Given 5. Storage of Medication 6. Other Directions, if Any Signature of Parent Date	(Specify, prescribed medication	/over the counter products)		(Child's Name)	
8. Times Medication is to be Given 4. Amount (dosage) of Medication Each Time Given 5. Storage of Medication 6. Other Directions, if Any Signature of Parent Date TO BE COMPLETED BY THE PROVIDER:	DIRECTIONS:		T		
5. Storage of Medication 5. Other Directions, if Any Signature of Parent Date TO BE COMPLETED BY THE PROVIDER:	Date to Begin Giving Medication		2. Date to Stop Medication		
5. Storage of Medication 5. Other Directions, if Any Signature of Parent Date TO BE COMPLETED BY THE PROVIDER:	3. Times Medication is to be Given		4. Amount (dosage) of Medication Each Time Given		
Signature of Parent Date O BE COMPLETED BY THE PROVIDER:			, ,		
O BE COMPLETED BY THE PROVIDER:	5. Storage of Medication				
O BE COMPLETED BY THE PROVIDER:	6. Other Directions, if Any				
O BE COMPLETED BY THE PROVIDER:					
	Signature of Parent			Date	
DATE TIME AMOUNT GIVEN BY WHOM	TO BE COMPLETED BY THE PROVIDE	R:			
	DATE	TIME	AMOUNT GIVEN	BY WH	IOM
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The Family Independence Agency will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to an FIA office in your county.